



Peer Assistance Services

**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
(Colorado State Board of Pharmacy)**

I, _____ hereby authorize Peer Assistance Services,
(Print client's first, middle, last name)

Inc. to release the following information, concerning me, to:

Colorado State Board of Pharmacy
1560 Broadway, Suite 1300
Denver, CO 80202

The purpose of this disclosure is to enable the Colorado State Board of Pharmacy to monitor, assist and/or follow the progress of the client and for any other purpose authorized by the Colorado Pharmacy Practice Act, C.R.S. § 12-22-101, et seq. Items and information to be released are:

- Treatment records
- Testing results
- Emergency-related information
- Reports of compliant and/or non-compliant behavior
- Assessment summary and/or recommendations
- Screening tool information
- Ability to practice with reasonable skill and safety
- Records received from other sources pertaining to client.
- Other _____

(specific record or records)

I further consent to the use and disclosure by the Colorado State Board of Pharmacy of any items or information released above for use in connection with investigation, disciplinary action, or any other purpose authorized by the Colorado Pharmacy Practice Act, C.R.S. § 12-22-101, et seq.

The confidentiality of alcohol and drug abuse records maintained by Peer Assistance Services, Inc., is protected by Federal laws and regulations. Generally, we may not say to a person outside the program that a client involved with Peer Assistance Services, Inc., attends the program or disclose any information identifying a client as an alcohol or drug abusers—unless: 1) You consent to the disclosure of information in writing; 2) The disclosure is ordered by a court; or as otherwise mandated by State and/or Federal law; 3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. If not sooner revoked, this consent shall expire three (3) years after my discharge from Peer Assistance Services, Inc. (42 C.F.R. § 2.31)

I understand that if I am a licensee is in a Peer Health Assistance Diversion Program and have a signed Diversion Program contract, my revocation of this consent may result in a report to the Colorado Board of Pharmacy for determination of noncompliance.

A copy of this document will have the same force and effect as the original.

Client Signature

Date

PEER ASSISTANCE SERVICES, INC. Start believing.

2170 South Parker Road, Suite 229 | Denver, Colorado 80231
TEL 303.369.0039 TOLL-FREE 1.866.369.0039 FAX 303.369.0982
www.peerassist.org | www.codrugfreeworkplace.org

Revised 8/25/09